MEDICAID MATERNITY CARE PROGRAM

EXTENDED DAYS NOTIFICATION FORM (TO BE FILED BY HOSPITALS ONLY FOR RECIPIENTS OUT OF IN-PATIENT DAYS ADMITTED FOR THE DELIVERY STAY)

_____ _____ ____ _____ _____ _____
Recipient Last Name First Name MI DOB Medicaid # District

_____
Delivery Date

Please list below the days paid by the primary contractor and hospital name.

(dd/mm/yy)
Days 1_____ 2_____ 3_____ 4_____ 5_____ 6_____

7_____ 8_____ 9_____ 10_____ 11_____ 12_____

13_____ 14_____ 15_____ 16_____

Please include copies of paid claims for the first 16 in-patient days.

_____

Please list the days included in the PA request (up to 18)

(dd/mm/yy)
Days 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____

8_____ 9_____ 10_____ 11_____ 12_____ 13_____

14_____ 15_____ 16_____ 17_____ 18_____

- PLEASE INCLUDE A HARD COPY CLAIM IN RED DROP-OUT INK FOR EXTENDED DAYS
- PLEASE NOTE___THE DAY OF DISCHARGE FROM THE HOSPITAL MAY NOT BE INCLUDED IN THE TOTALS FOR THE ABOVE.

Send this form and all information to the District Director of the recipient's residence.

1/9/2006